Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

STEPHEN E EARLE MD PA
PO BOX 33577
SAN ANTONIO TX 78265

Respondent Name
TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box
Box Number: 54

MFDR Tracking Number
M413-2745--01

MFDR Date Received
JUNE 25, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The initial bill of charges for this date of service was mailed by certified return receipt (Tracking Number 71012780000217644911) on November 18, 2012. However, the bill of charges was never received by Texas Mutual Insurance Company because the mailing was *lost by the Post Office*. As evidenced by the attached track and confirm, USPS was unable to locate the return receipt as it had been lost. The bill of charges was resubmitted to Texas Mutual Insurance Company on 2/26/2013. After speaking with a representative of the Texas Department of Insurance-Division of Workers Compensation, I can request a reconsideration of the medical bill if I provide the documentation to prove the mailing was actually lost. Please see the attached documentation."

Amount in Dispute: $28,050.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor performed surgical services to the claimant on the date above and then billed Texas Mutual for this. TM received the bill 3/1/13 and denied payment as untimely. (Attachment) The requestor argues it submitted the bill by certified mail to the carrier and has proof of that but Texas Mutual does not see the proof in the DWC-60 package. Further, neither Rule 133.20 nor Section 408.0272 of the Labor Code applies here."

Response Submitted by: Texas Mutual Insurance Co., 6210 E. Hwy 290, Austin, TX 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 16, 2012	Surgical Services	$28,050.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical

fee dispute.

2. 28 Texas Administrative Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.
3. 28 Texas Administrative Code §102.4 sets out the rules for non-Commission communications.
4. Texas Labor Code §408.027 sets out the rules for timely submission of a claim by a health care provider.
5. Texas Labor Code §408.0272 sets out the rules for certain exceptions for untimely submission of a claim by a health care provider.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 29 – The time limit for filing has expired.
   - 731 – Per 133.20 provider shall not submit a medical bill later than the 95th day after the date the service, for services on or after 9/1/05.
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - 891 – No additional payment after reconsideration.

Issues

1. Is the timely filing deadline applicable to the medical bills for the services in dispute?
2. Did the requestor forfeit the right to reimbursement for the services in dispute?

Findings

1. Texas Labor Code §408.027(a) states, in pertinent part, that "Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment." 28 Texas Administrative Code §102.4(h) states that "Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery, or electronic transmission or, (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday." Review of the submitted information finds that a copy of a USPS Track & Confirm was submitted, which states, "Delivery status information is not available for your item via this web site. A return receipt after mailing may be available through your local Post Office." The documentation does not show the date submitted, where it was sent, or what was sent. Therefore, no documentation to support that a medical bill was submitted within 95 days to the insurance carrier from the date the services were provided.
2. Therefore, pursuant to Texas Labor Code §408.027(a), the requestor in this medical fee dispute has forfeited the right to reimbursement due to untimely submission of the medical bill for the services in dispute.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

	Marguerite Foster	
Signature	Medical Fee Dispute Resolution Officer	Date

	Martha Luevano	
Signature	Manager, Medical Fee Dispute Resolution	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.